

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

December 6, 2023

[REDACTED], ADMINISTRATOR
BOARD OF DIRECTORS OF THE ROUSE ESTATE
615 ROUSE AVENUE
YOUNGSVILLE, PA, 16371

RE: SUITES AT ROUSE
615 ROUSE AVENUE
YOUNGSVILLE, PA, 16371
LICENSE/COC#: 46900

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/12/2023, 09/13/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: SUITES AT ROUSE License #: 46900 License Expiration: 12/24/2023
 Address: 615 ROUSE AVENUE, YOUNGSVILLE, PA 16371
 County: WARREN Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: BOARD OF DIRECTORS OF THE ROUSE ESTATE
 Address: 615 ROUSE AVENUE, YOUNGSVILLE, PA, 16371
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 08/02/1995 Issued By: Dept. of Labor & Industry
 Type: I-2 Date: 06/18/2019 Issued By: City of Warren

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 73 Waking Staff: 55

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 09/13/2023

Inspection Dates and Department Representative

09/12/2023 - On-Site: [REDACTED]
 09/13/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 120 Residents Served: 55
 Secured Dementia Care Unit
 In Home: Yes Area: Lower Level Capacity: 10 Residents Served: 7
 Hospice
 Current Residents: 0
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 55
 Diagnosed with Mental Illness: 10 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 18 Have Physical Disability: 0

Inspections / Reviews

09/12/2023 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/06/2023

Inspections / Reviews (*continued*)

10/16/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/21/2023

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/23/2023

10/20/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/21/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/01/2023

12/06/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/21/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

63a - First Aid/CPR Training

1. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted] there were 54 residents present in the home. From [redacted] to [redacted] on [redacted] there were no staff persons in the home certified in first aid, CPR and obstructed airway techniques.

On [redacted] there were 55 residents present in the home. From [redacted] to [redacted] and from [redacted] to [redacted] on [redacted] there were no staff persons in the home certified in first aid, CPR and obstructed airways techniques.

Plan of Correction

Accept [redacted] - 10/20/2023)

Director of Clinical Services has recently obtained a CPR and First Aid Trainer Certification through the Health and Safety Institute. This was obtained in May of 2023. (See attached card).

The Director of Clinical Services will be holding CPR and obstructed airway/First Aid classes on a minimum of a bi-weekly basis until adequate number of staff have been trained to meet the requirements of "one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times." When developing the direct care staff schedules the Director of Clinical Services will monitor and review the schedule to ensure these requirements are met. Monitoring will be done with each schedule posting on a bi-weekly basis. Completion by 11/30/23 and ongoing.

Director of Clinical Services has scheduled a CPR class for week of October 2nd. (See class roster).

Classes will be completed for direct care staff by Director of Clinical Services by 11/30/23 and ongoing as needed.

Licensee's Proposed Overall Completion Date: 11/30/2023

Implemented [redacted] - 12/06/2023)

85e - Trash Outside Home

2. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/12/23 the home's exterior dumpster lid was open at 10:45am.

Plan of Correction

Accept [redacted] - 10/16/2023)

The dumpster lid was closed on 9/12/23 by Maintenance.

85e - Trash Outside Home (continued)

Signs were placed on fencing surrounding the dumpster indicating to staff that dumpster lids must be closed at all times. This was done on 9/12/23 by Maintenance. (See attached photos.)

All staff will sign off policy titled, "Sanitation" with emphasis on keeping the dumpster lid closed. Completed by Administrator by 10/31/2023

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented () - 12/06/2023)

92 - Windows

3. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 9/12/23 in the home's Secure Dementia Care Unit, the left side kitchen window had no screen at 10:40 a.m.

Plan of Correction

Accept () - 10/16/2023)

Screen in the Secure Dementia Care Unit was replaced on 9/13/23 by Maintenance. (See photos)

Full facility audit was completed on 9/13/23 by Maintenance. (Audit attached).

During morning facility walk through, Monday - Friday, maintenance will monitor physical site for deficient or missing window screens. This will be documented on the Maintenance Monthly Checklist (See attached audit sheet) To be completed by Maintenance. 10/31/23 and on going.

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented () 12/06/2023)

103e - Left Overs

4. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 9/12/23 there was an opened, undated container of sour cream in the home's bar room kitchen refrigerator at 11:01 a.m.

103e Left Overs (continued)

Plan of Correction

Accept (█ - 10/16/2023)

The opened, undated container was removed from the refrigerator on 9/12/23 and disposed of by Administrator.

A sign was placed on the refrigerator by Nutritional Services Supervisor stating that all food must be covered, labeled and dated. This was completed on 9/27/23. (See attached photo).

The refrigerator in this area is one that is to be locked unless the bar is in use. Henry's bar will be audited weekly by Nutritional Services Supervisor or designee of the Dietary department to ensure all food items are labeled and dated. This will be completed by 10/31/23. (See attached audit sheet.)

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented (█ - 12/06/2023)

103i - Outdated Food

5. Requirements

- 2600.
- 103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 9/12/23, in the home's food storage area, 2 dented cans of salmon were observed at 10:36 a.m.

Plan of Correction

Accept (█ - 10/20/2023)

Dented cans were removed by the Nutritional Services Supervisor on 9/12/23.

A full audit of all inventory was conducted on 9/27/23 by Nutritional Services Supervisor. (See attached)

All inventory will be audited by dietary staff when received from vendors. This audit will be completed on Tuesdays and Fridays, or other days of the week if delivery dates change. This will be completed by Dietary staff or Nutritional Services Supervisor on a weekly basis. Audits to start on 10/13/23 and ongoing. (See audit form).

All dietary staff will sign off on an understanding of the audit process. This will be completed by Nutritional Services Supervisor by 10/31/23.

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented (█ - 12/06/2023)

132d - Evacuation

6. Requirements

- 2600.
- 132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home exceeded an evacuation time of 15 minutes during the following drills:

132d Evacuation (continued)

4/21/23 at 6:00am, 10 staff persons evacuated 60 residents in 15 minutes 26 seconds.

Plan of Correction

Accept () - 10/20/2023)

Education given to Maintenance and Administration who conduct fire drills on safe evacuation times as determined by the fire safety expert. Education to be completed by Administrator by 10/23/23. (See attached sign off sheet)

For all fire drills conducted times will continue to be recorded and monitored. This will be conducted by Maintenance on a monthly basis.

For all fire drills, the drill will continue to be reviewed with all participants and any questions addressed. Ways to improve the drill will be discussed and documented on the fire drill record. This will be completed by Maintenance monthly. Completion date of 10/31/23.

If a drill is conducted and it is over the safe evacuation time, a second drill will be completed within 2 days to measure improvement and that safe evacuation time was met. This will be completed by Maintenance and Administrator. Next facility fire drill is in October. Completion date of 10/31/23 and on going monthly. (See attached Fire Drill Record)

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented () - 12/06/2023)

132g - Fire Drills Days/Times

7. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds sleeping hour fire drills at the same approximate time of day as evidenced by the following drills:

4/21/23 at 6:00 a.m.

10/31/22 at 6:20 a.m.

7/21/22 at 5:45 a.m.

1/8/22 at 6:30 a.m.

11/22/21 at 6:15 a.m.

Plan of Correction

Accept () - 10/16/2023)

Maintenance will review with Administrator the sleep time fire drills prior to being conducted. Maintenance and Administrator will review past sleep time drill times to ensure they are being conducted during sleep time of 11pm 7am and that they are at different times. 10/31/23.

Next sleep time drill to be completed in October between the hours of 1am 2am. Completed by Maintenance and Administrator by 10/31/23.

132g - Fire Drills Days/Times (continued)

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented [redacted] - 12/06/2023)

184a - Resident's Meds Labeled

8. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is prescribed [redacted] instill 1 drop in both eyes 2 times a day. However, the pharmacy label indicates, instill 1 drop in left eye every 12 hrs.

Resident #1 is prescribed [redacted], Apply to affected area topically as needed for pain, may use up to 3 patches daily. However, the pharmacy label indicates, apply 1 patch topically daily. Wear for 12 hrs. only. Do not wear patch at night.

Plan of Correction

Accept [redacted] - 10/16/2023)

Resident #1s medications were clarified with primary care physician and corrected on 9/13/23. (See order clarifications attached).

Direct care staff that are medication trained will be educated to notify Team Lead or LPN if there are difference between the medication order and pharmacy label for clarification. This will be completed by Director of Clinical Services and LPN by 10/31/23.

LPN will audit no less than 5 residents medications per month to ensure that the order match's the pharmacy label. The audits will begin on 10/2/23 to be completed by 10/31/23 and continue monthly. (See Attached Audit form).

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented [redacted] - 12/06/2023)

227d - Support Plan Medical/Dental

9. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

227d - Support Plan Medical/Dental (continued)

Description of Violation

Resident #1 began receiving home health services on [REDACTED], however, the resident's support plan, dated [REDACTED], does not indicate any information on these services.

Resident #2 is self-administering medications since [REDACTED], however, the resident's annual support plan dated [REDACTED] indicates the resident cannot self-administer medications.

Plan of Correction

Accept ([REDACTED] - 10/16/2023)

Resident #1's RASP was updated by the Resident Care Coordinator to include home health services on [REDACTED].

Resident #2's RASP was updated by the Resident Care Coordinator to indicated that the resident is able to self administer medications on 9/14/23.

The Geriatric Assessment Team, consisting of the Administrator, Director of Clinical Services, Social Worker, LPN and Resident Care Coordinator, will review weekly any resident who within the week have started outside services, or self administration so that RASP's can be updated accordingly. This will be started 10/5/23.

The Resident Care Coordinator will audit no less that 5 residents RASP's monthly to ensure that all services residents are receiving are properly documented and that self administration is properly marked. This will start 10/2/2023 with a completion date of 10/31/23 and on going. (See attached audit form).

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented [REDACTED] /06/2023)